CITY OF

ALBUQUERQUE

Employer-Sponsored Group Benefits

CONTRACT YEAR
July 1, 2008 - June 30, 2009

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This brochure is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans. Please be aware that some of the benefits listed in the various tables have limitations. See your Summary Plan Description (SPD) for more details. This brochure does not constitute a contract of employment nor does it change your employment-at-will status.

Your employer retains the right to modify benefits or premiums during annual contract negotiations to obtain benefits for employees.

CITY OF ALBUQUERQUE

MARTIN J. CHAVEZ, MAYOR

Dear Fellow Employees:

The City of Albuquerque is pleased to provide one of the most comprehensive benefit packages in New Mexico. And this year, our benefit offerings are expanding in three very important areas.

The City has recently extended employee banking options to include Payroll Debit Cards. We now offer the option of a non-City sponsored payroll debit card plan with a financial institution or payroll service provider of your choice. Payroll card features include:

- Re-loadable ACH,
- ATM and POS terminal access,
- Card personalization for the account holder, and
- Activity and balance information available through the Internet.

Payroll debit cards are an alternative to traditional checking accounts and provide the option of loading all or part of your payroll check onto a convenient debit card that can be utilized at ATM and POS terminals. Enjoy the option of loading a special debit card for vacation planning, holiday shopping or your kids' allowance! For your convenience, information on two payroll debit card plans, *Bank of America CashPay Card and Debit Direct's Payroll Card*, is provided with your benefits packet.

This plan year, a voluntary "Permanent Whole Life Insurance" benefit will be offered. Permanent Whole Life Insurance gives employees and their dependents access to an individual life insurance plan that features guarantee issue amounts, premium payments that stop at age 65, complete portability, convenient payroll deduction, and, best of all, the City of Albuquerque has secured group rates that never go up!

It is also with great excitement that we announce the launch of the City's first Employee Wellness Program. Did you know that chronic diseases related to lifestyle accounts for 70% of all healthcare spending? That means the personal choices we make about diet and exercise have a direct and profound impact on our healthcare costs and insurance premiums. In the upcoming months I look forward to joining you at the series of Fun Walks, Nutritional Seminars, and Healthy Activities that your City Employee Wellness Program is bringing this year.

I would also like to take this opportunity to remind you about the truly great savings that can be realized by participating in Flexible Spending Accounts. If you pay money out-of-pocket for day care for your children (or even parents in some instances), routinely have expenses for co-pays, medical supplies, eyeglasses or prescriptions, you can save money by participating in our Flexible Spending Accounts.

Please review the handbook for more information about our new whole life insurance option, the pre-tax benefits of Flexible Spending Accounts, and our exciting Employee Wellness program. And we will, of course, continue to offer a comprehensive benefit program, which includes medical, prescription, dental, vision, basic and supplemental life insurance.

Our HR Insurance & Benefits Office will be conducting a series of Employee Benefit Seminars in areas across the City for your convenience. I hope you will take advantage of the many opportunities the City offers to stay informed and access benefits that will improve your physical and financial health. If at any time you have any questions about your Group Health Benefit Program, please contact the Insurance and Benefits Division of Human Resources Department at (505) 768-3758.

Best Wishes,

Martin J. Chavez, Mayor

Rules and Regulations – Guidelines for Enrollment

These rules and regulations apply to employees of the City of Albuquerque and other government entities (i.e. counties, villages, etc.) that have elected to participate in the same insurance plans. There may be differences in eligibility between entities. For example, not all governing bodies of the entities have approved allowing an employee's domestic partner and his/her children to be eligible for insurance coverage. Entities also differ in the employer contribution towards insurance premiums. Please check with your employer's Benefits Office for clarification.

A. Who is Eligible

1. Permanent employees (including those on probation)
2. Elected officials
3. Unclassified employees scheduled to work 20 hours or more each week
4. Legal spouse of an employee
5. Domestic partner of an employee*
6. Children that are financially dependent on the employee, unmarried and under age 25 AND meet at least one of the following criteria:
    a. Natural child of the employee, spouse or domestic partner
    b. Placed in the employee's home and in process for being adopted by the employee, spouse or domestic partner
    c. Adopted by the employee, spouse or domestic partner
    d. Court order that requires the employee, spouse or domestic partner provide medical insurance coverage for the child
    e. Court document that shows the employee, spouse or domestic partner has full, permanent custody of the child
    f. Children over age 25 may **continue** participating in the group insurance plans if they are physically or mentally handicapped and are not eligible for any other plan. This continuation is subject to normal enrollment guidelines and approval by the insurance carrier.

* A domestic partner is defined as a person of the same or opposite sex who lives with the employee in a long-term relationship of indefinite duration. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child meets the definition of eligibility stated above. Note the criteria and required documents in the *Changing Benefit Elections* section.

B. Benefit Options

Options may vary by participating entity but usually include:

1. Medical Insurance
2. Dental Insurance
3. Vision Insurance
4. Life Insurance
5. Long Term Disability Insurance
6. Flexible Spending Accounts (Medical, Dependent Care, Parking/Transit)

C. Coverage Options

1. Employee Only
2. Employee Plus Spouse or Domestic Partner
3. Single Parent
4. Family

D. Changing Benefit Elections and Qualifying Events

Many of the rules for enrollment and eligibility are made by the Internal Revenue Service because they allow your salary to be reduced by the premiums you pay before taxes are calculated (Internal Revenue Code Section 125.) Important rules to know are:

Once you have made an election during your initial enrollment period of 31 days from your hire date then you are **locked into that decision until the next open enrollment.**

Exceptions to this are qualifying events due to a life status change. You must provide documentation of the life status change and complete forms within **31 days of the qualifying event**. Qualifying events and acceptable documents are:

1. Marriage - Marriage certificate
2. Domestic Partnership meeting eligibility requirements – Affidavit
3. Divorce – Court issued divorce decree
4. Birth – Hospital certificate or state issued birth certificate
5. Death – Death certificate
6. Change in employment status affecting benefits eligibility (for you or your spouse) - Letter/form from employer that is notification of the job change, coverage ending or new eligibility
7. Involuntary loss of coverage – Official notification of loss
8. Dependent child losing eligibility - Official notification of loss
9. Dependent change of residence that affects benefits eligibility - Notification of change

The **Affidavit of Domestic Partnership** is a legal document in which both the employee and the domestic partner swear that they meet the following criteria:

1. Both are unmarried
2. Reside in the same residence for at least 12 months and intend to do so indefinitely
3. Meet the age requirements for marriage in the state of New Mexico
4. Are not related by blood to the degree prohibited in a legal marriage in the State of New Mexico
5. Are financially responsible for each other's welfare and share financial obligations

In addition to the notarized affidavit, three of the following documents are also required.

1. Joint lease/mortgage or ownership of property
2. Jointly owned motor vehicle, bank or credit account (only one qualifies)
3. Domestic partner named as beneficiary of the employee's life insurance
4. Domestic partner named as beneficiary of the employee's retirement benefits
5. Domestic partner named as primary beneficiary in the employee's will
6. Domestic partner assigned as power of attorney or legal designee by the employee
7. Both names on a utility bill
8. Both names on an investment account

The employee's domestic partner is not required to visit the Insurance & Benefits Office in order to receive benefits. The employee may bring the signed and notarized Affidavit of Domestic Partnership with the other required documents.

The Federal Government does not recognize domestic partners as qualified dependents and therefore the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the city for the domestic partner and his/her covered children. Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding qualifying events.

Missing the initial enrollment period, 31-day qualifying event period or the annual open enrollment period, may result in **delayed enrollment**, a delay in notification of loss of coverage and **paying for coverage no longer provided**.
The effective date will depend on the event and when documents and forms are submitted to your employer (see below.)

Name/Address Changes: It is important to keep your employer and the insurance plans informed when you experience a name and/or address change to prevent a disruption of service and receipt of important policy information. Please visit the Insurance and Benefits Office to complete forms which will be forwarded to the proper carriers.

E. Effective Date of Coverage, Changes and/or Terminations

1. **New employees** – Coverage begins on the first day of the current pay period if forms are completed and required documents are brought to New Employee Orientation (NEO) or are submitted to the Insurance & Benefits Office by the end of the first week. You have 31 days from your hire date to submit completed forms

and verification of dependent eligibility. If not on the hire date then coverage will begin on the first day of the pay period following the submission of completed forms and verification of dependent eligibility.

2. **Qualifying Events** – Coverage begins on the first day of the pay period following the submission of completed forms, verification of dependent eligibility and documentation of the qualifying event as long as the forms and documents are received in the Insurance and Benefits Office within 31 days from the event. The only exception to this is when the event is the birth of a child. The coverage begins on the date of birth if documentation and forms are completed and submitted to the Insurance & Benefits Office within the 31-day enrollment period.
3. **Open Enrollment** – Benefit changes elected during open enrollment are effective on July 1st for new coverage. Changes that cancel coverage are effective on June 30th.
4. **Termination of Coverage** - Insurance ends at the end of the pay period in which the event occurs. Exceptions to this are the termination of coverage due to retirement and a dependent child losing eligibility under the plan. In these cases, coverage ends at the end of the month in which the event occurs.
5. **Reinstatement Resulting From the Grievance Process** – Reinstated employees must visit their Benefits Office within 31 days of their reinstatement date to reenroll in the benefits they had at the time of separation. A copy of the reinstatement agreement must be provided and all other eligibility requirements apply.

F. Open Enrollment

This is a three week period established annually (usually in May) that allows all benefit eligible employees to make changes to their benefit elections without having experienced a qualifying life status change. It is the only opportunity to switch plans (such as changing from the Presbyterian Active Plan to their Independent Plan.) Annual premium changes also occur at this time and will automatically be updated on your first paycheck in July without you having to make a new election.

G. Insurance Premium and Benefit Plan Participation Payments

The insurance premiums listed in this booklet are stated as biweekly amounts. The benefit payments are deducted for coverage during the same two week period for which you are paid. Your earnings are reduced by your portion of the medical, dental and vision insurance premiums before Federal, State and FICA taxes are calculated, thereby saving you money.

Employees are responsible for paying their Group Insurance Premiums regardless of receiving a paycheck. This means if your employment status is "active" and you do not receive a paycheck then you will be responsible for paying the employee AND the employer portion of your medical, dental, vision premiums, and also your current deduction(s) for other supplemental benefits in that period. You will be responsible for making payment arrangements through the Insurance and Benefits Office (contact information is provided in the back of this booklet). Payment arrangements depend on the situation and will be looked at on an individual basis. Failure to either make payment arrangements or to make timely payments will result in cancellation of benefits back to the last pay period for which the premiums were paid.

NOTE: You are exempt from having to pay the employer's portion if you are on military leave or approved leave under The Family Medical Leave Act.

H. COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is the federal law that allows the employer to offer continued participation in medical, dental, and/or vision group insurance coverage if your employment terminates (18 months maximum) or your covered dependent loses eligibility (36 months maximum.) Domestic partners of employees, and any covered children, are eligible for continuing coverage when their eligibility ends under the active employee plans, even though providing the option is not required by law. Electing to continue coverage must be made within 60 days of the date eligibility was lost on the active employee plans. The cost of the coverage is 102% of the full monthly premium. You will receive written notification of your rights and responsibilities when you or your dependent experience an event that qualifies. Additional information is available in the Insurance and Benefits Office.

Your Employee Wellness Program

The City of Albuquerque, in partnership with CIGNA HealthCare and Presbyterian Health Plan, is committed to focusing more on you and your health in 2008 and beyond. We are proud to be offering a comprehensive wellness program for all City employees this year. We are concerned about the health and well-being of employees and their families, as well as the escalating cost of health care coverage to individuals on our plans and to the City.

Your Employee Wellness Program is designed to:

- Help provide a healthful work environment
- Support the adoption of healthy habits to improve individual health and fitness levels
- Provide increased knowledge of and access to health promotion, health education, disease reduction and other programs and resources to benefit employee well-being

We are pleased to offer the following Wellness benefits:

- A series of wellness seminars on topics such as: smoking cessation, weight management, and stress management
- A monthly wellness newsletter filled with information, inspiration, and motivation
- Employee Wellness Fairs featuring access to a wide array of vendors and partners
- Health Screenings **offered at no charge** to enable employees easy and convenient access to important measurements and education
- Accurate, up-to-date Health information on both our City Employee Website and Gov TV channel

Help make this effort an even greater success! For more information, to submit your story of healthful living, or to become a "Wellness Champion" for your department, please contact JD Maes, your wellness coordinator, at 768-2921 or jmaes@cabq.gov

How can you improve your health in just 15-20 minutes?

Complete the online Health Risk Assessment (HRA) and get connected to a healthier way of life. The confidential HRA will assess your current lifestyle choices and personal & family health history to provide immediate personalized feedback. This customized report is only available if you are participating in a City sponsored medical insurance program, and will give you tools to improve or maintain your family's health. Log on today!

For CIGNA HealthCare members:

- Go to www.myCIGNA.com
- Click on "REGISTER" or "Member Log In" (if already registered)
- Select "I Want to…Take the Health Risk Assessment"
- Complete the questionnaire

For Presbyterian Health Plan Members:

- Go to www.phs.org
- Select "Login to Pres Online or Register
- Select Healthy Advantage
- Select Health Risk Assessment, Complete the questionnaire

Additional Benefits of Completion:

- Access to tools and programs based on your areas of personal health risk
- Information on improving your health and well being with a focus on what's a priority to *you*
- Knowledge of choices you're making that actually protect your health
- Steps you can take to get the most from your doctor visits and health plan benefits

City of Albuquerque
Bi-weekly Insurance Rates FY2009
July 1, 2008 - June 30, 2009

Medical Insurance - Employee pays 17% Employer pays 83%

Presbyterian My Care Health Plan				**CIGNA HealthCare Open Access Plus**			
	EMP BW*	ER BW	Total BW		EMP BW	ER BW	Total BW
Single	26.46	129.17	155.63	Single	25.88	126.37	152.25
Couple	53.83	262.81	316.64	Couple	50.11	244.64	294.75
S/Parent	42.50	207.48	249.98	S/Parent	45.26	220.99	266.25
Family	77.68	379.28	456.96	Family	74.33	362.93	437.26

Dental Insurance - Employee pays 17% Employer pays 83%

Delta Dental				**United Concordia Dental**			
	EMP BW	ER BW	Total BW		EMP BW	ER BW	Total BW
Single	2.28	11.15	13.43	Single	2.07	10.09	12.16
Couple	4.56	22.28	26.84	Couple	4.42	21.57	25.99
S/Parent	4.74	23.13	27.87	S/Parent	4.57	22.29	26.86
Family	6.38	31.17	37.55	Family	6.16	30.06	36.22

Vision Insurance - Employee pays 17% Employer pays 83%

Davis Vision			
	EMP BW	ER BW	Total BW
Single	0.39	1.92	2.31
Couple	0.74	3.62	4.36
S/Parent	0.79	3.83	4.62
Family	1.18	5.75	6.93

Long-Term Disability Insurance (voluntary)

CIGNA	Biweekly
Age	Rate per $1 of BW Salary
<30	0.00262
30-39	0.00406
40-44	0.00536
45-49	0.00770
50-54	0.01004
55-59	0.01199
60>	0.01238

Whole Life Insurance (voluntary)

Globe Life
Rates vary by age and benefit amount selected

Flexible Spending Account (voluntary)

BASIC (medical, dependent care, parking or transit fee) $4.55 City Paid Monthly

* Biweekly = monthly times 12 divided by 26

Basic Life and AD&D

CIGNA (100% Paid by City)
Amount of coverage is 104% of gross annual salary with a minimum of $25,000 and maximum of $50,000

Supplemental Term Life (voluntary)

CIGNA Biweekly Rates Per $10,000		
Age	Smoker	Non Smoker
<30	0.443	0.215
30-34	0.550	0.275
35-39	0.882	0.443
40-44	1.218	0.658
45-49	2.258	1.271
50-54	3.381	1.880
55-59	4.925	2.709
60-64	6.248	3.486
65-69	9.230	5.198
70-74	17.577	9.786
75-79	27.290	15.194
80 +	65.573	36.572

CIGNA Dependent Child Term Life	
Coverage	Rate
$2,500	0.240
$5,000	0.480
$7,500	0.720
$10,000	0.960

Medical Plans

Plan Benefits

Each of the medical plan options provides comprehensive medical coverage for enrolled members. On the next pages you will find a general description of each of the plans, followed by a Benefits-At-A-Glance chart comparing key benefits of both plans. Finally, you will see a list of exclusions for items that neither of the plans cover.

In order to choose the plan that is right for you and your family, review the benefit levels for each plan, as well as the medical providers available to you.

Keep in mind this information is a summary only, and you should refer to each plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choices

You have the option to choose between two medical plans:

- Presbyterian Health Plan My Care Plan
- Cigna Open Access Plan

Cost of Coverage

No matter which plan you choose, your employer will pay a portion of the premium. The chart below shows your portion of the cost, which is taken on a per pay period basis. As you can see, your cost depends on the plan you choose as well as what family members you enroll.

	Bi-Weekly (26 Pay Periods) Contributions			
	Presbyterian My Care Plan		Cigna Open Access Plan	
	Employee	Employer	Employee	Employer
Employee only	$26.46	$129.16	$25.88	$126.37
Employee and spouse	$53.83	$262.81	$50.11	$244.64
Employee and children	$42.50	$207.48	$45.26	$220.99
Employee and family	$77.68	$379.28	$74.33	$362.93

CIGNA HealthCare Open Access Plus Plan

for Employees of the City of Albuquerque and Participating Entities

Choice and Convenience

CIGNA's Open Access Plus plan provides freedom & features you want

1. Comprehensive, In-Network coverage

The CIGNA HealthCare plan offers access to providers and hospitals in New Mexico and across the country through a vast, seamless network. In Albuquerque, members may access the Lovelace Health System (providers and facilities), University of NM and many Independent Provider practices, including many Behavioral HealthCare providers contracted by CIGNA Behavioral Health. You can find any provider by visiting **www.CIGNA.com**. Simply enter the name of the city or a zip code for a complete listing.

The plan does not require you to select a Primary Care Physician (PCP); members may seek care with any contracted provider. We encourage you to maintain a relationship with your PCP since he or she can be a valuable resource and personal health advocate.

When you visit a contracted provider (either a PCP or a Specialist) who is **in-network**, you will have the lowest out of pocket costs.

For example*:

- $15 PCP office visit copay
- $25 specialist care office visit copay
- Coverage for preventive services (like routine physicals and well care)
- Pre-admission Certification and Prior Authorizations are obtained by in-network provider
- No claim forms

Referrals are not required for Specialty care

2. Choice to visit Out-of-Network (non-contracted) providers

With out-of-network benefits, you can see any licensed provider you wish and still be covered for treatment of illnesses and injuries. You do not need to select a PCP or get referrals to see specialists. Keep in mind that the amount you pay out of your pocket will be higher if you choose a doctor who doesn't participate in our networks.

For example*:

- Pay 50% coinsurance, instead of copays
- Meet an annual deductible of $1,000
- File your own claim forms
- Pre-admission Certification for hospital stays and Prior Authorization for outpatient services may be required. You are responsible for making sure they are obtained.

* Refer to your summary plan description/benefit summary for full detail.

CIGNA HealthCare Well Aware Program for Better Health®

You don't want a chronic illness to control your life. Now you have a resource to help you manage your chronic illness with personalized action plans and support. We have eight separate programs:

- Asthma
- Diabetes
- Heart disease
- Low back pain
- Chronic obstructive pulmonary disease
- Weight complications
- Targeted Conditions
- Depression

Call 1.877.888.3091 or visit **www.cigna.com** for more information about Well Aware.

CIGNA HealthCare 24-Hour Health Information Line℠

Registered nurses are available 24 hours a day, seven days a week with expert, reliable information to answer your health questions, help you find facilities and identify available options and treatments. In addition, there are hundreds of recorded audio programs in the Health Information Library.

Call 1.800.564.8982 for information about the Health Information Line.

CIGNA HealthCare Healthy Rewards

Expand your health options at discounted prices. Through Healthy Rewards, you get access to a full range of health and wellness programs and services often not covered by traditional insurance plans.

Some examples:

- Weight Watchers®
- Jenny Craig weight loss
- CURVES
- QuitNet and Tobacco Solutions smoking cessation programs
- Chiropractic care and massage therapy
- Acupuncture
- Hearing aids and tests
- Anti-cavity products

Visit **myCIGNA.com** or call 1.800.870.3470 for more information on Healthy Rewards.

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CIGNA HealthCare provides you the tools to meet your health care needs online at www.myCIGNA.com

Tel-Drug/Pharmacy

- Home delivery of the medications you take regularly
- 24-hour ordering by mail, phone or online
- Free, prompt, confidential shipping
- Fast answers – Questions about medications, copayments or coverage? Just call us toll-free. We even offer 'round-the-clock urgent pharmacy services.
- It's a service of CIGNA HealthCare – We care about quality and safety! To try CIGNA Tel-Drug for your next prescription, call us toll-free to QuickSwitch® at 1.800.285.4812 (choose option #1) or visit our online Prescription Center at **www.teldrug.com**.

myCIGNA.com

Turn to CIGNA for the Wellness Advantage

Visit myCIGNA.com or call Member Services to learn about the many programs and tools that can help guide you and your family to better health. You can also use myCIGNA.com to create a personal health profile that can offer steps for improvement and links to helpful resources.

Online access to YOUR benefits and new resources at your personal, confidential portal. It's an easy and convenient way to manage your CIGNA HealthCare coverage. You can:

- Take an online questionnaire that can help you identify and monitor your health status
- Record and store personal health information in central, secure location
- Compare hospitals according to your unique needs and preferences
- Learn about and compare drug treatment options, and compare medications
- Get answers to frequently asked questions, verify benefits, order a new ID card, check claim status, and much more

Register today at **myCIGNA.com**

If your pregnancy may be putting your health – and the health of your baby-at risk: Our case managers can discuss your health risks and get you resources to help minimize those risks. We can provide information on a healthy pregnancy and give you phone access to registered nurses.

If you want to quit smoking: Look for CIGNA Quit Today® Tobacco Cessation Programs. Our CIGNA Quit today program helps you develop a personal quit plan to become and remain tobacco free.*

I**f you feel stressed:** Look for Strength and Resilience® our stress management program helps you understand the sources of your stress. Learn coping techniques and manage stress both on and off the job.*

*For each program, you have the option of a telephone program with focused attention from a personal wellness coach or a flexible online program featuring weekly emails with motivational information and tips. Or choose both.

If you want help improving your health and well-being: You can access online resources through Web MD at myCIGNA.com or call the toll-free number on your CIGNA HealthCare ID card and listen to programs on exercise, nutrition and weight control.

And there's more…

CIGNA HealthCare, in collaboration with the City of Albuquerque Wellness Program, is offering Health Education and Wellness Screenings to City of Albuquerque employees. We look forward to continuing our support of the City's wellness initiatives while also offering the ongoing, customized disease management and health promotion resources mentioned above.

The City of Albuquerque's focus for 2008 is:

- Metabolic Health
- Weight Management
- Smoking Cessation

CIGNA HealthCare offers a variety of services and programs to support you and your family on your personal quest for improved health and well being. Whether you go online to **www.mycigna.com**, call the 1-800CIGNA24, or visit us at a 2008 City of Albuquerque event, CIGNA wants to be your partner in overall health and wellness.

To find an In-Network provider, you can either visit **www.cigna.com** or refer to your CIGNA HealthCare Provider Directory.

For more information about services and benefits, call Member Services at 1.800.CIGNA 24 (244.6224)

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My Care

One plan, three benefit options

With Presbyterian Health Plan's My Care Plan, employees can choose among three different benefit options to find a plan that best fits their unique needs: the Active, Family, and Independent options.

Once you select an option, you and your qualifying dependents will remain in that option until the next open enrollment. Each option is priced the same, and your per pay period contribution is the same for all options. The benefit levels vary as outlined below.

The Active Option

The Active option is a good fit for individuals, couples, or some families who do not seek medical services often and are mainly concerned with preventive care. The Active option allows you to seek medical services from participating providers and offers a $150 reimbursement per family per contract year under the Unique Services Reimbursement Program for the following:

- Preventive care copays
- Gym memberships*
- Weight loss programs*
- Routine vision care
- Ambulance copays
- Copays for X-rays
- Sterilization services
- Smoking cessation
- Birth control pills
- LASIK surgery
- Vitamins*
- Dental treatment*

The Family Option

The Family option is great for those employees with a family-oriented lifestyle. These individuals typically have young children or are expecting to start a family. Instead of offering a Unique Service Reimbursement Program, this option offers significantly lower copayments for the services that children use most. Well-child care and preventive physical exams are only $5 for children enrolled on this plan and office visits are $10 for children.

The Independent Option

The Independent option is designed for individuals, couples, or families who want to visit doctors outside the Presbyterian network and receive coverage for those costs. This plan offers enhanced out-of-network coverage, allowing you to visit providers outside of the Presbyterian Health Plan provider network. This option offers a $250 reimbursement per family per contract year under the Unique Services Reimbursement Program for the following:

- Preventive care copays
- Prescription drug costs with a physician's prescription
- Routine vision care
- Alternative therapies
- Disease management classes*
- Dental treatments*
- Diagnostic devices*
- Hearing aids

* If recommended by a physician to treat a specific medical condition. A note or prescription from the provider and the Unique Services Reimbursement Form must be submitted.

- Three coverage options designed to accommodate different lifestyles
- You can choose the one that meets your needs
- Two options offer special reimbursements
- You don't need to select a Primary Care Physician (PCP) under any option

Remember…

Preventive care copays are eligible for reimbursement under your Unique Services Reimbursement Program. See your plan booklet for limitations and filing instructions.

For more information about services and benefits, call Member Services at (505) 923-5678 or 1-800-356-2219 between the hours of 7:00 a.m. to 6:00 p.m., Monday through Friday.

Feel better.
Stay healthy.
Live well.

Providing health care to New Mexico for nearly a century, Presbyterian is uniquely woven into the fabric of this state. Being community owned, we are dedicated to improving the health of individuals, families and communities and will be here when you need us. As an active partner with the City of Albuquerque, we provide employees with the tools they need to feel better, stay healthy and live well.

Feel better.

Pres e-Care
Pres e-Care allows members who have an established relationship with a participating provider to communicate about non-urgent symptoms through a webVisit® for a $5 copay. There is no charge for routine communications, such as appointment requests, lab results, and prescription refills. Visit www.phs.org/e-care for more information.

Nurse Advice Line 1-866-221-9679
Registered nurses are available 24 hours, 7 days a week to answer questions about specific health problems and to provide assistance with self-care of minor illnesses or injuries.

Stay healthy.

Healthy Advantage Wellness Program
Together, the City of Albuquerque and Presbyterian offer an interactive wellness program to help you improve and maintain your health and well-being. Through health risk assessments, onsite screenings, flu-shot clinics, health fairs, and more, members can follow the steps to healthier living.

Selecting a Physician
Another good way to stay healthy is to become established with a practitioner who can serve as a partner for good health and can help you make the best decisions about your overall medical care. You may locate a practitioner with our convenient, online directory at www.phs.org/directory or call Member Services at (505) 923-5678 or 1-800-356-2219 between the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday.

Live well.

Value Added Discounts
Presbyterian members receive valuable discounts for acupuncture, chiropractic care, massage therapy, hearing hardware, and more through participating BenefitSource providers.

Smoking Cessation Program
If you'd like to quit smoking or using tobacco products, call the Tobacco Quit Line, 1-888-840-5445, for confidential support at no additional cost.

ADAM
Members with a medical question can visit ADAM, a free website offering a wealth of trustworthy health information, anytime via a link at www.phs.org. ADAM also provides useful wellness tools to help you estimate your healthy body weight, target heart rate, amount of body fat and more.

Medical Benefits At-A-Glance

The following is only a summary, some benefits may have further limitations or exclusions.

	CIGNA Open Access Plan		Presbyterian My Care
			Active
	In-Network	**Out of Network**	
Annual deductible	None	$1,000 ind. $2,000 family	None
Annual out-of-pocket costs	$1,500 individual, $3,000 family	$3,000 ind. $6,000 family	Twice your annual premium
Lifetime maximum	Unlimited		Unlimited
Physician services			
Office visit	$15 co-pay per visit	50% after plan deductible[3]	$20 co-pay per visit
Specialist visit	$25 co-pay per visit		$30 co-pay per visit
Allergy testing	$25 co-pay per visit	50% after plan deductible	You pay 20%
Injections	$25 co-pay per visit, $15 co-pay if PCP	50% after plan deductible[3]	Included in office visit co-pay
Infertility services	$25 co-pay per visit, $15 co-pay if PCP	50% after plan deductible[3]	You pay 50%
Gynecological exam	$25 co-pay per visit, $15 co-pay if PCP	50% after plan deductible[3]	$20 co-pay
Pre and post natal care	$25 co-pay per initial visit, no charge for all other routine visits	50% after plan deductible[3]	$20 co-pay per visit up to $200 per pregnancy
Diagnostic X-ray			
MRI	$75 co-pay[1]	50% after $150 per procedure deductible and plan deductible[1 3]	$125 co-pay per test
Cat Scans	$75 co-pay[1]	50% after plan deductible[1 3]	$75 co-pay per test
Cardiac Cath	$150 co-pay[1]	50% after plan deductible[1 3]	$200 co-pay per test
X-Ray and Laboratory	No charge	50% after plan deductible[3]	No charge
Urgent care	$25 co-pay urgent, $15 co-pay non appointment care	50% after plan deductible[3]	Participating provider: $25 co-pay Non-participating provider: $50 co-pay
Emergency room	$75 co-pay,waived if admitted	50% after plan deductible[3]	$75 co-pay per visit, waived if admitted
Ambulance	No charge	50% after plan deductible[3]	$50 co-pay (ground), $100 co-pay (air)
Hospital			
Inpatient	$250 co-pay per admission[1]	50% after $500 per admit deductible and plan deductible[1 3]	$150 co-pay per day up to $450 per admission[1]
Outpatient	$150 co-pay[1]	50% after $250 per admit deductible and plan deductible[1 3]	$150 co-pay per visit[1]
Speech, physical, occupational therapy Outpatient	$20 co-pay per visit (60 visits per calendar year combined includes acupuncture)[1]	50% after plan deductible[1 3]	$30 co-pay per visit[1] (2 months per condition)
Acupuncture	See speech therapy	50% after plan deductible[3]	$30 co-pay per visit (20 visits per calendar year, medical necessity)
Durable medical equipment	No charge (up to $1,000 per calendar year)*[1]	50% after plan deductible[1 3]	You pay 50%[1]
Chiropractic	See speech therapy	50% after plan deductible[1 3]	$30 co-pay per visit (18 visits per calendar year, medical necessity)
Home Health Care	No charge (100 visits max per calendar year)*[1]	50% after plan deductible[1 3]	No charge[1]
Hospice	No charge[1]	50% after plan deductible[1 3]	$150 co-pay per day up to $450 per admission[1]
Skilled nursing care	No charge (60 days per calendar year)*[1]	50% after plan deductible[1 3]	$150 co-pay per day up to $450 per admission (60 days per calendar year) [1]
Dialysis	$150 co-pay per admission	50% after plan deductible[1 3]	You pay 20% per visit
Mental Health			
Inpatient	$250 co-pay per admission[1]	50% after $500 per admit deductible and plan deductible[1 3]	$150 co-pay per day up to $450 per admission[1]
Outpatient	$25 co-pay per visit	50% after plan deductible[3]	$30 co-pay per visit[1]
Substance Abuse			
Inpatient	$50 co-pay per day (30-day max per calendar year)*[1]	50% after $50 per day deductible and plan deductible[1 3]	Detox: $150 co-pay per day up to $450 per admission[1,3*] Rehab: 25% co-pay per admission[1,3*]
Outpatient	$25 co-pay for first 2 visits, $25 thereafter (20 visit max per calendar year)*	50% after plan deductible[3]	$30 co-pay per visit[1] (30 visits per calendar year)
Prescription drugs			
Retail	Generic $10, brand $35, non-preferred or brand name with generic equivalent 50%	In-network coverage only	Generic $10, brand $35, non-preferred $55 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, $10 plus difference in cost
Mail Order	Generic $20, brand $70, non-preferred or brand name with generic equivalent 50%	In-network coverage only	Generic $20, brand $87.50, non-preferred $165 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, $20 plus difference in cost

[1] Prior authorization/benefit certification applies.

[3]Benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges.

For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Presbyterian My Care		
Family	**Independent**	
	Network	**Out-of-Network**
None	None	$500 individual, $1,500 family
Twice your annual premium	Twice your annual premium	$6,000 individual, $18,000 family
Unlimited	Unlimited	$2 million
$25 co-pay (adult), $10 co-pay (child)	$25 co-pay per visit	You pay 40%
$35 co-pay (adult), $20 co-pay (child)	$35 co-pay per visit	You pay 40%
You pay 20%	You pay 20%	You pay 40%
Included in office visit co-pay	Included in office visit co-pay	You pay 40%
You pay 50%	You pay 50%	Not covered
$25 co-pay (adult), $10 co-pay (child)	$25 co-pay	You pay 40%
$25 co-pay per visit up to $250 per pregnancy	$25 co-pay per visit up to $250 per pregnancy	You pay 40%
$200 co-pay per test (adult) $100 co-pay per test (child)	$125 co-pay per test	You pay 40%[1,4]
$125 co-pay per test (adult) $75 co-pay per test (child)	$75 co-pay per test	You pay 40%[1,4]
$300 co-pay per test (adult) $175 co-pay per test (child)	$200 co-pay per test	You pay 40%[1,4]
No charge	No charge	You pay 40%[1,4]
Participating provider: $35 co-pay (adult), $20 co-pay (child), Non-participating provider: $45 (adult), $30 co-pay (child)	$35 co-pay	$45 co-pay no deductible
$75 co-pay per visit, waived if admitted	$75 co-pay per visit, waived if admitted	$75 co-pay per visit no deductible
$50 co-pay (ground), $100 co-pay (air)	$50 co-pay (ground), $100 co-pay (air)	$50 co-pay (ground), $100 co-pay (air)
$150 co-pay per day up to $450 per admission (adult)[1] $100 co-pay per day up to $300 per admission (child)[1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1, 4]
$200 co-pay per visit (adult), $100 co-pay per visit (child)[1]	$125 co-pay per visit[1]	You pay 40%[1, 4]
$35 co-pay per visit (adult), $20 co-pay per visit (child) (2 months per condition)	$35 co-pay per visit (2 months per condition)	You pay 40%[1, 4] (2 months per condition) Speech therapy not covered out-of-network
$35 co-pay (adult), $20 co-pay (child); (20 visits per calendar year, medical necessity)	$35 co-pay per visit (20 visits per calendar year, medical necessity)	You pay 40%
You pay 50%[1]	You pay 50%[1]	You pay 50%[1,4]
$35 co-pay (adult), $20 co-pay (child) (18 visits per calendar year, medical necessity)	$35 co-pay per visit (18 visits per calendar year, medical necessity)	You pay 40%
No charge[1]	No charge[1]	You pay 40%[1,4]
$150 co-pay per day up to $450 per admission (adult) $100 co-pay per day up to $300 per admission (child)[1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1,4]
$150 co-pay per day up to $450 per admission (adult) $100 co-pay per day up to $300 per admission (child) (60 days per calendar year) [1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1,4]
You pay 20% per visit	You pay 20% per visit	You pay 40%
$150 co-pay per day up to $450 per admission (adult)[1] $100 co-pay per day up to $300 per admission (child)[1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1,4]
$35 co-pay (adult), $20 co-pay (child) per visit[1]	$35 co-pay per visit[1]	You pay 40%[1,4]
Detox: $150 co-pay per day up to $450 per admission (adult)[1]; $100 co-pay per day up to $300 per admission (child)[1]; Rehab: 25% co-pay per admission[1]*	Detox: $150 co-pay per day up to $450 per admission[1]; Rehab: 25% co-pay per admission[1,4] *	You pay 40%[1,4]
$35 co-pay per visit (adult)[1]; $20 co-pay per visit (child)[1] (30 visits per calendar year)	$35 co-pay per visit[1] (30 visits per calendar year)	You pay 40%[1,4]
Generic $10, brand $30, non-preferred $50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $10 plus difference in cost	Generic $10, brand $30, non-preferred $50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $10 plus difference in cost	Not covered unless an emergency outside service area (deductible doesn't apply)
Generic $20, brand $75, non-preferred $150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $20 plus difference in cost	Generic $20, brand $75, non-preferred $150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $20 plus difference in cost	Not covered

[4] A 15% penalty applies if benefit certification is not obtained.
*20 visits and 1 episode per calendar year, 3 episodes per lifetime.

Exclusions to Coverage for the Medical Plans

The following exclusions and limitations apply to both the CIGNA HealthCare and the Presbyterian Health Plan My Care medical plans. Items with a "*" may be eligible for reimbursements under the Presbyterian Health Plan Unique Services Reimbursement Program (See page 10 for a summary)

Any exclusion listed would not be applicable if Covered under FIT Program in accordance with that which is required under N.M.S.A.§ 59A-46-38.1. Refer to your Group Subscriber Agreement for details.

- Alternative/complementary therapies, except as specified in the Group Subscriber Agreement (GSA)*
- Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not medically necessary or accepted medical practice
- Artificial aids including speech synthesis devices except items identified in the Group Subscriber Agreement (GSA)
- Athletic trainers*
- Autopsies and/or transportation costs for deceased Members
- Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings
- Benefits and services not specified as covered
- Biofeedback, except as specified in the Group Subscriber Agreement (GSA)
- Cancer Clinical Trials are limited to phase 2, 3 and 4 and must be provided for in the State of New Mexico in accordance with the provisions set forth in the Group Subscriber Agreement (GSA)
- Care for conditions which State or local law requires be treated in a public or correctional facility
- Care for military service connected disabilities to which the member is legally entitled and for which facilities are reasonably available to the member
- Charges that are determined to be unreasonable by the carrier
- Circumcisions performed other than during the newborn's hospital stay unless medically necessary
- Clothing or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not
- Co-dependency treatment
- Convenience items
- Cosmetic surgery, treatments, devices, orthotics, and medications, including treatment of hair-loss
- Costs for extended warranties and premiums for other insurance coverage
- Counseling - sex, pastoral/spiritual, and bereavement counseling
- Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as alcohol or substance abuse programs and/or psychiatric evaluation or therapy
- Covered services obtained from a non-participating provider/practitioner, except as provided in the Group Subscriber Agreement (GSA) (Not applicable to the Presbyterian Independent option or to the services eligible for reimbursement under the Unique Services Reimbursement Program services)
- Custodial or domiciliary care - including but not limited to eating, bathing, dressing or other self care activities or homemaker services.
- Dental care and dental x-rays, except as provided in the Group Subscriber Agreement (GSA)*
- Dental implants*
- Disposable medical supplies, except when provided in a hospital or a physician's office or by a home health professional
- Donor sperm
- Exclusions related to covered durable medical equipment - additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty
- Elastic support hose
- Elective abortions after the 24th week of pregnancy
- Elective Home Birth and any prenatal or postpartum services connected with an elective home birth
- Emergency facility used for non-emergent services
- Exercise equipment and videos, personal trainers, club memberships and weight reduction programs*
- Experimental/Investigational, as determined by the carriers, drugs, medicines, treatments or procedures
- Extracorporeal shock wave therapy involving the musculoskeletal system
- Eye movement therapy.
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques*
- Eyeglasses (Corrective) or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Group Subscriber Agreement (GSA)*
- Foot care (routine), except as provided in the Group Subscriber Agreement (GSA)
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided
- Gloves, unless part of a wound treatment kit
- Hair-loss (or baldness) treatments, medications, supplies and devices including wigs, and special brushes
- Halfway houses
- Hearing aids and the evaluation for the fitting of hearing aids
- Home sleep studies
- Hospice benefits are not available for the following services: food, housing and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under durable medical equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling
- Hypnotherapy except as part of anesthesia preparation or chronic pain
- Infant formula
- In-vitro, GIFT and ZIFT fertilization
- Lay midwife - Services of a lay midwife or an unlicensed midwife
- Malocclusion treatment, if part of routine dental care and orthodontics
- Massage therapy, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program
- Medical and hospital services of a donor when the recipient of an organ transplant is a not a member or when the transplant procedure is not covered
- New medications for which the determination of criteria for coverage has not yet been established by the carrier
- Nutritional supplements except as provided in the Group Subscriber Agreement (GSA)*
- Organ transplants (Non-human), except for porcine (pig) heart valve
- Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures*
- Orthodontic appliances and orthodontic treatment, crowns, bridges, and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related*
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant neuropathies
- Orthotics (functional foot), except as provided in the Group Subscriber Agreement (GSA) for patients with diabetes or other significant peripheral neuropathies
- Orthotics/orthosis (Custom Fabricated) except as specified in the Group Subscriber Agreement (GSA).
- Over-The-Counter (OTC) medications except as specified in the Group Subscriber Agreement (GSA).
- Personal or comfort items, services or treatments
- Photophoresis for all conditions other than mycosis fungoides
- Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-medically necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment
- Prescription drugs received upon hospital discharge, provided by a hospital pharmacy unless a participating outpatient pharmacy is not available*
- Prescription drugs requiring a benefit certification when benefit certification was not obtained*
- Prescription drugs ordered by a non-participating provider or purchased at a non-participating pharmacy unless required due to an emergency occurring outside of the service area*
- Prescription drug, compounded medications*
- Prescription drug replacements due to loss, theft, or destruction*
- Private duty nursing
- Psychological testing when not medically necessary
- Residential treatment centers unless for the treatment of alcoholism and/or substance abuse rehabilitation
- Reversals of voluntary sterilization - male or female
- Services for which the member is eligible under any governmental program (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the member or dependent
- Services requiring bcenefits certification when benefit certification was not obtained
- Sex transformation surgery and drugs relating to sex transformation
- Sexual dysfunction treatment, including medication, counseling, and clinics, except for penile prosthesis as provided in the Group Subscriber Agreement (GSA)
- Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the Group Subscriber Agreement (GSA) for more information
- Special medical foods, except as listed as covered in the Group Subscriber Agreement (GSA) for Genetic Inborn Errors of Metabolism
- Storage or banking of sperm, ova (human eggs), embryos, zygotes, or other human tissue
- "Telephone visits and electronic mail (E-mail)" by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient
- Transportation costs for deceased members
- Travel and lodging expense, except as provided in the Group Subscriber Agreement (GSA)
- Vision care (routine) and eye refractions for determining prescriptions for corrective lenses, except as listed as covered in the Group Subscriber Agreement (GSA)*
- Visual training
- Vocational rehabilitation services and long-term rehabilitation services
- Weight reduction or control treatments, except for medically necessary treatment for morbid obesity*
- Work-related accidents or injuries or occupational illness or disease if the member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists

The following is also not covered by the CIGNA HealthCare plan:

- Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear, loss or damage.
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services as noted in the Group Service Agreement (GSA)
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

The following is also not covered by the Presbyterian Health Plan My Care plan:

- Independent option - The following services are not covered on the out-of-network option: Organ transplants, infertility services, cardiac and pulmonary rehabilitation, covered mediations, prescription drugs, specialty pharmaceuticals and special medical foods.

The above is only a summary, some benefits may have further limitations or exclusions. For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Dental Plans

Plan Benefits

Each of the dental plan options provides comprehensive dental coverage for enrolled members. On the next pages you will find a general description of each of the options, followed by a Benefits-At-A-Glance chart comparing key benefits of the plans.

In choosing a dental plan it is important to consider the types of services covered and the dental providers available to you. Benefits are based on four main classifications of services:

- **Diagnostic and Preventive** usually includes: cleanings, exams, X-rays, sealants and fluoride treatments
- **Basic** usually includes: fillings, root canals, periodontics, extractions, oral surgery and general anesthesia
- **Major** usually includes: crowns, bridges and dentures
- **Orthodontics** usually includes: diagnostic and retention treatment

Keep in mind this information is a summary only, and you should refer to each plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choices

You may choose to enroll yourself and your eligible dependents in one of two dental options:

- Delta Dental Plan of New Mexico
- United Concordia Flex

Cost of Coverage

No matter which plan you choose, your employer will pay a portion of the premium. The chart below shows your portion of the cost, which is taken on a per pay period basis. As you can see, your cost depends on the plan you choose as well as what family members you enroll.

	Bi-Weekly (26 Pay Periods) Contributions			
	Delta Dental Plan		United Concordia Flex Plan	
	Employee	Employer	Employee	Employer
Employee only	$2.28	$11.15	$2.07	$10.09
Employee and spouse	$4.56	$22.28	$4.42	$21.57
Employee and children	$4.74	$23.13	$4.57	$22.29
Employee and family	$6.38	$31.17	$6.16	$30.05

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City of Albuquerque and Participating Entities... Enroll Today!

More dentists, more choice, more opportunities for savings on the cost of dental care.

Delta Dental PPO℠	Delta Dental Premier®
• Over 560 points of access in New Mexico. • Over 99,000 dentist locations nationally, with dentists in all 50 states. • Features a fee schedule that helps make dental services more affordable and reduces out-of-pocket costs at the time services are received. • Preventive care covered at 100% when a Delta Dental PPO dentist is selected.	• The broadest selection of dentists – over 370 points of access in the Albuquerque Metro area. • With over 174,000 dentist locations nationally, and dentists in all 50 states, Delta Dental Premier is the nation's most extensive dental network. Featuring over 930 Points of Access around the state, more than 90% of the dentists in New Mexico participate in Delta Dental Premier.

Delta Dental Online Resources—Available 24/7

Fast, free, and easy ways for enrollees to access personalized benefit information, oral health information, privacy policies and more. No software to purchase or download required.

Consumer Toolkit

- Verify eligibility of subscriber and dependents
- Confirm status of deductibles and plan maximums
- Review how a specific claim was processed
- Print a personalized subscriber ID card

Featured Subscriber Information Available

- Summary of Benefits
- Dental Benefit Handbook
- Network Information Page
- Provider Directory

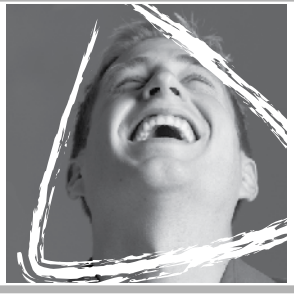
Telephone: (505) 883-4777
Toll Free: (800)-999-0963
Fax: (505) 883-7444

Benefit Services: (505) 855-7111
Toll Free: (877) 395-9420

All claims and customer service provided locally.

No frustrating phone "menu of options" from which to choose.

Talk to a local representative within 45 seconds calling!



Great service is our way of saying "Thank you for your enrollment."

www.deltadentalnm.com / Subscriber Section

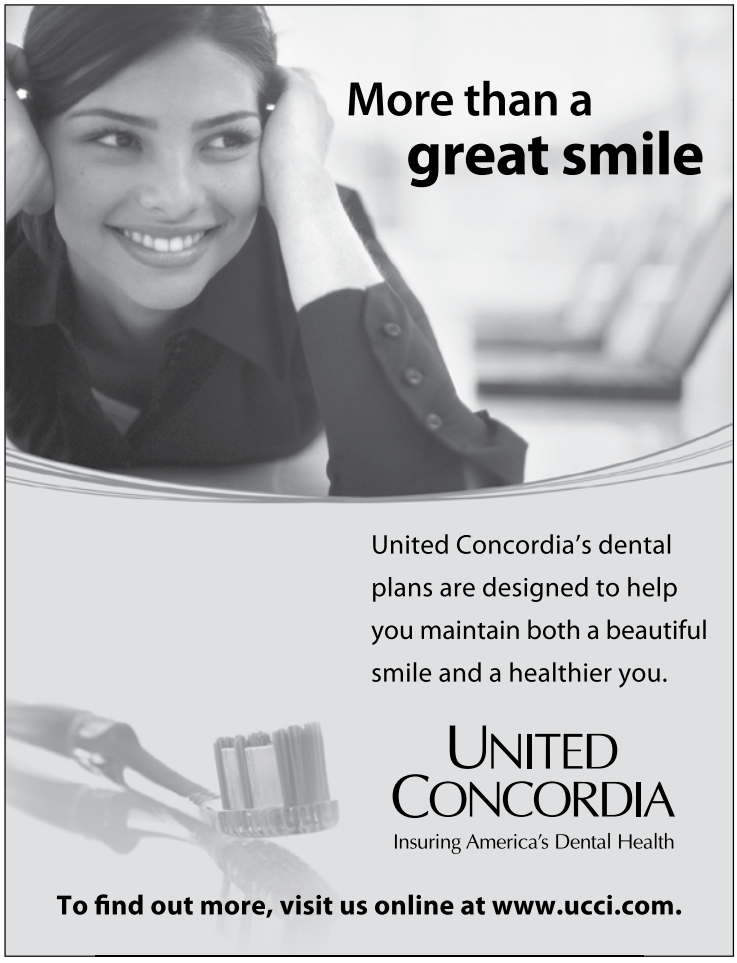
United Concordia

Now is the time for you and your dependents to join Concordia Flex, the dental plan from United Concordia.

How the United Concordia Dental Plan Works

Through Concordia Flex, you have access to the Concordia Advantage *Plus* network of dentists, endodontists, periodontists, pedodontists, oral surgeons and orthodontists. With more than 83,500 dental locations nationwide and 660 dentist locations in New Mexico, a United Concordia network dentist is only a phone call or mouse click away. **Using a network dentist helps benefit your smile and your wallet since United Concordia Advantage *Plus* network providers have agreed to accept the contracted fee as payment-in-full and have agreed to file claims for you.**

The plan also provides you with the freedom to seek care from any licensed dentist. The choice is yours.



United Concordia is the *only* dental plan offering:

- ★ **$2,000 per person annual maximum**
- ★ **Orthodontics paid at 60% to $1,500!**
- ★ **Cleanings, x-rays, exams, sealants and emergency treatment paid at 100%* regardless of where you receive services!**

Make the right choice for you and your family—Enroll today.

**Based on in-network contracted fees; additional costs may apply for services received from non-network providers.*

UNITED CONCORDIA
Insuring America's Dental Health

Dental Benefits At-A-Glance

This is a highlight of the benefits only. Refer to your member certificate or group subscriber agreement for specific details, including limitations and exclusions.

	Delta Dental of New Mexico	
	PPO Network	**Premier Network**
Annual Benefit Maximum (per plan year)	$1,500 per person	
Deductible	$50 per person, $150 family (lifetime max)	
Lifetime Orthodontic Benefit Maximum	$1,200 per person	
Diagnostic and Preventive Services		
Examples of Diagnostic and Preventive Services include: Cleanings, Exams, X-rays, Fluoride treatment, Sealants, Emergency treatment for the relief of pain	Plan pays 100% no deductible applies	Plan pays 80% no deductible applies
Basic Services		
Examples of Basic Services include: Fillings, Stainless steel crowns, Root canals, Periodontics, Oral surgery, Prescription medications for dental related conditions	Plan pays 85% subject to deductible	Plan pays 85% subject to deductible
Major Services		
Examples of Major Services include: Specified implant services, Crowns, Partial or complete dentures, Bridges	Plan pays 50% subject to deductible	Plan pays 50% subject to deductible
Orthodontic Services		
Diagnostic, active and retention treatment for adults and children	Plan pays 50%	Plan pays 50%

The benefit levels shown are subject to the applicable Delta Dental Maximum Approved Fees, which are less for Delta Dental PPO dentists than Delta Dental Premier dentists. Because the cost of dental care is less when treatment is received from a Delta Dental PPO dentist, receiving services from these dentists, whenever possible, will result in lower out-of-pocket costs.

Out-of-pocket costs may be significantly higher if services are received from a dentist who does not participate in one of Delta Dental's provider networks. Maximum Approved Fees are greatly reduced for out-of-network services, and non-participating dentists may balance patients up to the full amount of their submitted charges.

Enrolled persons are entitled to a PRE-DETERMINATION OF BENEFITS anytime more costly procedures are anticipated. When requested by a dental provider, an advance estimate of benefits payable can be provided by Delta Dental before dental care services are received. Pre-determination is strongly recommended and there is no charge for this service.

	United Concordia
	Advantage Plus Network
Annual Benefit Maximum (per plan year)	$2,000 per person
Deductible	$50 individual, $150 family (lifetime max)
Lifetime Orthodontic Benefit Maximum	$1,500 per person*
Diagnostic and Preventive Services	
Examples of Diagnostic and Preventive Services include: Cleanings, Exams, X-rays, Fluoride treatment, Sealants, Emergency treatment for the relief of pain	Plan pays 100% of allowable amount, no deductible applies[4]
Basic Services	
Examples of Basic Services include: Fillings, Stainless steel crowns, Root canals, Periodontics, Oral surgery, Prescription medications for dental related conditions	Plan pays 85% of allowable amount after deductible**
Major Services	
Examples of Major Services include: Specified implant services, Crowns, Partial or complete dentures, Bridges	Plan pays 50% of allowable amount after deductible
Orthodontic Services	
Diagnostic, active and retention treatment for adults and children	Plan pays 60% up to lifetime maximum

[4]Flouride: 2 per year up to age 19. Sealants: permanent molars only.

*Only applies to new treatment plans on or after July 1, 2007.

**Amalgam fillings on posterior teeth. Composite resin fillings for anterior teeth only.

Benefit percentages shown above are based on the in-network contracted fees or provider's charge, whichever is less. Additional out-of-pocket cost may apply to non-network providers.

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THE EYECARE ADVANTAGE

The Importance of Annual Eye Examinations

Did you know that a Dilated Fundus Evaluation can detect up to 30 systemic diseases? That's right... in addition to ensuring proper eyesight, regular eye examinations allow doctors to detect and treat diseases at the earliest possible opportunity. The eyes are the window into the entire body, and a comprehensive eye examination can be as important for your overall health, as it is, for ocular health. An eye examination that includes dilation (Dilated Fundus Evaluation) can uncover signs of hypertension, AIDS, arteriosclerosis, diabetes, Graves' disease, stroke, high cholesterol and many other conditions, as well as common eye disorders.

Annual comprehensive eye examinations are of vital importance in preventing and/or delaying eye disease for those at higher risk for eye disease, such as those over age 65, people with diabetes and African Americans over age 40.

Children's Eye Examinations

Visual disorders can be detected in children as young as six months. Eye examinations for infants, preschoolers and school-age children can protect against vision-threatening disorders. The American Public Health Association recently issued an official policy resolution urging regular eye examinations for all children. Treatment for visual development or eye health problems will be most effective when introduced at the earliest stages. Ideally, well-child eye examinations should begin at age three and be scheduled regularly thereafter to ensure there is no evidence of eye disease.

Vision Impacts Learning

Children under 12 learn by visual cues. In the first 12 years, 80% of all learning takes place visually. Visual impairment can significantly handicap a child's intellectual and emotional growth, as well as social development. Vision problems affect one in four children between the ages of five and 12. Many parents rely on vision screenings offered in schools or by pediatricians to detect vision concerns, but these screenings are not through. They can detect vision problems in only 20%-30% of children, and may not expose problems of eye muscle coordination, eye disease, peripheral vision or shortcomings in near/distance vision. A thorough eye examination should be provided.

Healthy eyes... healthy lives!

Vision Plan

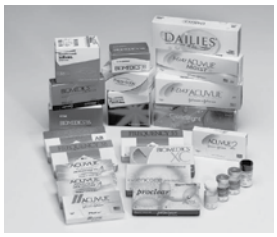
Employees are offered vision care benefits through Davis Vision. Remember routine eye examinations are not offered through the medical plans.

Davis Vision Plan Benefits

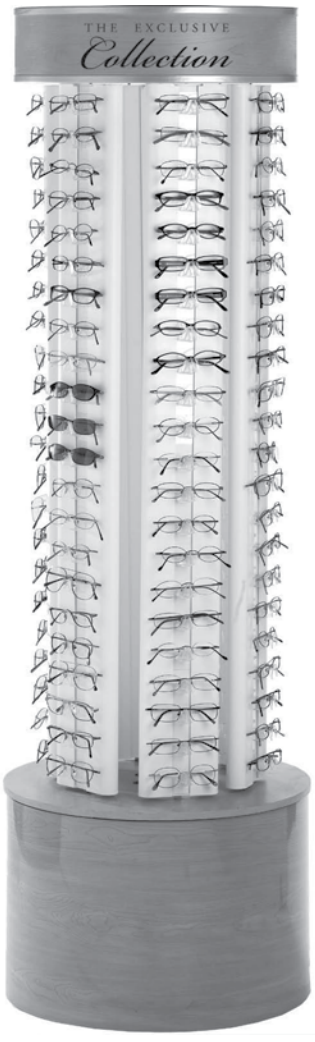
The Vision Plan offers coverage for general vision benefits such as eye examinations, eyeglasses and contact lenses throughout the state. Providers represent all types of vision specialists, including: private optometrists, ophthalmologists, free-standing retail stores and optical centers located within national retail department stores. Call 1-800-999-5431 to find a network provider near you or access the directory online at www.davisvision.com.

A description of coverages is listed below. Keep in mind that this information is a summary only, and you should refer to the plan's official Summary Plan Description for full details, including all limitations and exclusions.

Service	Frequency	In-Network Coverages	Out-of-Network Reimbursement[1/]
Eye Examination (includes Dilated Fundus Evaluation)	Every 12 Months	Covered in full after $10 copayment	up to $35
Spectacle Lenses	Every 12 Months	Covered in full after $15 copayment	up to:
Single-vision			$25
Bifocal			$40
Trifocal			$55
Lenticular			$80
Frames	Every 24 Months	Premier Collection frame covered in full after $15 copayment, OR $40 wholesale frame allowance (equivalent to $80 - $120 retail value) toward any non-Collection frame	up to $35
Contact Lenses (in lieu of eyeglasses)	Every 12 Months	Formulary Lenses covered in full, OR $110 allowance, plus 15% discount off any overage toward non-Formulary lenses	up to $110
Medically necessary (prior approval required)		Covered in full	up to $210



Contact Lens Formulary



Exclusive Frame Collection

[1/] To request claim forms, visit www.davisvision.com or call 1-800-999-5431. Completed claim forms should be sent to Davis Vision directly for reimbursement. Send to: Vision Care Processing Unit, P.O. Box 1525, Latham, N.Y. 12110.

Cost of Coverage

When you enroll in the vision plan, you are responsible for part of the premium cost, which is taken on a per-pay-period basis. As shown, the amount depends on which family members you enroll.

	Bi-Weekly (26 Pay Periods) Contributions	
	Employee	**Employer**
Employee only	$0.39	$1.92
Employee and spouse	$0.74	$3.62
Employee and children	$0.79	$3.83
Employee and family	$1.18	$5.75

As a safeguard to protect the utilization of the Vision Plan, City of Albuquerque and participating entities have a 2-year enrollment requirement under this plan. You and each member of your family have to fulfill the 2-year enrollment requirement before you can drop vision coverage.

Basic Life and AD&D Insurance

If you are an eligible permanent full-time or part-time employee, you are covered by the CIGNA basic life and accidental death and dismemberment (AD&D) plan. The City provides this coverage at no cost to you.

Basic Life Benefit
If you die, the plan will pay your designated beneficiary a benefit of 1.4 times your basic yearly compensation, rounded to the next higher $1,000. Regardless of the amount of your basic yearly compensation, the benefit will not be less than $25,000 or greater than $50,000.

When you retire, your coverage will reduce by 50%. Your employer will continue to provide this coverage at no cost to you. You may convert the lost coverage as outlined below.

Converting Your Coverage
When your coverage is reduced or ends (for any reason except nonpayment of premiums) you can convert the lost coverage to an individual permanent life insurance policy. No medical certification is needed. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after group coverage ends. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed.

Accident Insurance Benefit
The plan will also pay benefits for losses due to covered accidents. A covered accident is a sudden unforeseeable event that results in injury or death and that occurs while coverage is in force. The AD&D benefit amount is the same as the Basic Life benefit amount. The full benefit will be paid in the event of accidental loss of life occurring within 365 days of a covered accident. Or, to help survivors of severe accidents adjust to new living circumstances, a percentage of the benefits will be paid for dismemberment and/or loss of eyesight.

Waiver of Premium
If you become totally disabled – To make sure you can keep the life insurance protecting you during a difficult period of your life, this plan provides a waiver of premium feature. If you submit proof that you became totally disabled prior to age 60 and have remained continuously totally disabled at least 9 months, your coverage will continue until age 65, subject to proof of continuing disability each year. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness.

Will Preparation Program
When you are covered by CIGNA life insurance, CIGNA's Will Center makes it easy for you to take charge of difficult life and health legal decisions. There are no more reasons to hesitate planning for the future with the online will preparation service. You can easily complete essential life and health legal documents online at no cost to you. CIGNA's Will Center is secure, easy to use, and available to you seven days a week, 365 days a year. Go to CIGNAWillCenter.com. To access your Personal Estate Planning web page, simply complete the online form and register as a new user. Once registered, you can immediately start building your will and other legal documents.

CIGNA®
A Business of Caring.

Learn More

To learn more, call 505-768-3758.

Voluntary Life Insurance

If you would like to purchase additional life insurance protection for you or your dependents, you may do so through CIGNA's voluntary life insurance. You must be a full-time employee and work a minimum of 20 hours per week to be eligible. This plan is a voluntary plan, meaning if you participate you are responsible for the entire cost of the premium.

Voluntary Coverage for Yourself

You can buy coverage for yourself in increments of $10,000 up to $500,000. If you purchase an amount greater than $250,000 or increase coverage after initial eligibility, you will need to provide evidence of insurability. Death benefits will be reduced by 50% at age 70. And, your coverage ends when you retire. Reduced or terminated coverage may be converted to an individual permanent life insurance policy. Please refer to your Group Insurance Certificate, or to the conversion brochure available from Human Resources, for details.

If you become totally disabled before turning 60 years old, your coverage will remain in force without needing to pay premiums provided the insurance company approves you for this waiver of premium benefit. There is a nine-month waiting period and benefits will continue to age 65, as long as you remain totally disabled and provide proof each year. If you become terminally ill, you may receive 50% of your death benefit up to $250,000.

When you enroll in the voluntary life plan, you pay the premium cost through payroll deductions. The chart to the right shows your cost depending on your age and whether or not you smoke. You are considered a smoker if you used any form of tobacco in the last 12 months. Deductions are taken on a per pay period basis.

A sample contribution calculation

Employee	*$250,000 ÷ 10,000 = 25 units*		
(age 28, non-smoker)	25 units X $0.215 per unit	=	$5.38
Spouse/Domestic Partner	$100,000 ÷ 10,000 = 10 units		
(age 24, smoker)	10 units X $0.443 per unit	=	$4.43
Children	$10,000 benefit level	=	$0.96
	Total Bi-weekly Cost		**$10.77**

Voluntary Coverage for Your Dependents

If your spouse/domestic partner or child is also an employee of the same employer, they may only be covered as an employee or a dependent. No one may be covered as both an employee and spouse/domestic partner or employee and child.

If you decide to purchase coverage for your spouse/domestic partner, you may purchase coverage in increments of $10,000 up to $500,000, whether or not you purchase coverage for yourself. Rates are based on age and whether or not your spouse/domestic partner smokes. They are considered a smoker if they used any form of tobacco in the last 12 months. If you purchase an amount of dependent life coverage greater than the coverage amounts in the table to the right or increase coverage after initial eligibility, evidence of insurability will apply, which means you need to supply proof of good health which is acceptable to the insurance company.

You can also enroll your children in the plan. Coverage starts for children at least 14 days old through age 25. You can purchase coverage in increments of $2,500 to a maximum of $10,000. Coverage is limited to $500 for children 14 days to six months old. You and/or your spouse/domestic partner must be enrolled to enroll your dependent children.

Additional AD&D Coverage

When you and/or your spouse/domestic partner enroll in voluntary life insurance you automatically receive additional AD&D coverage of $20,000.

Rate Per $10,000

Age	Smoker Rate	Non-Smoker Rate
Less than 30	$0.443	$0.215
30-34	$0.550	$0.275
35-39	$0.882	$0.443
40-44	$1.218	$0.658
45-49	$2.258	$1.271
50-54	$3.381	$1.880
55-59	$4.925	$2.709
60-64	$6.248	$3.486
65-69	$9.230	$5.198
70-74	$17.577	$9.786
75-79	$27.290	$15.194
80 and older	$65.573	$36.572

Employee Coverage Amount	Spouse/Domestic Partner Coverage Guaranteed Amount
$50,000	$10,000
$100,000	$20,000
$150,000	$30,000
$200,000	$40,000
$250,000	$50,000

Child Coverage Amount	Rate
$2,500	$0.240
$5,000	$0.480
$7,500	$0.720
$10,000	$0.960

Guarantee issue is available only at initial eligibility. All other requests for coverage are subject to underwriting approval. Rates for age 75 and over apply to active, full-time employees only. Spouse/domestic partner coverage ends at age 75. Suicide is excluded for the first two years of voluntary life coverage. Exclusions for the AD&D coverage will be listed in the enrollment brochures. This is a summary of group term life insurance coverage available under CIGNA Group Insurance. For specific provisions, please contact the City of Albuquerque Insurance Office (505-768-3758). Underwritten by Life Insurance Company of North America. This information is a brief description of the important features of the plan. It is not a contract. In the event of a discrepancy between this summary and the group insurance policy, benefits will be paid according to the terms and conditions of the policy. Please refer to your Life Insurance Company of North America brochure for a complete description of benefits, limitations and exclusions.

Supplemental Whole Life Insurance Benefit Program

for Employees of the

City of Albuquerque

and Participating Entities

A Sponsored Benefit

As an employee of the City of Albuquerque or participating entities, you have the opportunity to purchase these optional Life coverages from Globe Life And Accident Insurance Company.

☐ **Ordinary Life** (Whole Life Insurance)
Paid-Up At 65

- Coverage For Employee & Family
- Guaranteed Issue Face Amounts*

Employee (up to Age 55):	$75,000
Spouse (up to Age 55):	$25,000
Children (up to Age 23):	$7,000

- Premiums Remain Level, then Stop at **Age 65 when coverage is fully paid up** — no rate increases ever
- Graded Benefit available**

☐ **Ordinary Life** (Whole Life Insurance)
Paid for Life

- Coverage For Employee & Family
- Guaranteed Issue Face Amounts*

Employee (Age 56 - 80):	$30,000
Spouse (Age 56 - 80):	$10,000

- Premiums Remain Level for life — no rate increases ever
- Graded Benefit available**

QUESTIONS?

Call Us: 1-866-738-4500

505-883-2527

Licensed Representatives will be at your location to make presentations, answer questions and help you with the application process.

Globe Life And Accident Insurance Company

	Ordinary Life **(Whole Life Insurance)** *Paid-Up at Age 65*	**Ordinary Life** **(Whole Life Insurance)** *Paid for Life*

Select the level of supplemental Life coverage needed, as well as any additional riders.

POLICY BENEFITS

Guaranteed Face Amount* *If applicant has certain pre-existing medical conditions, policy will be issued with graded benefits.*** *Excess amounts over the Guaranteed Face Amount subject to regular underwriting.*	**Employee** (*Age 18 - 55*): up to **$75,000**	**Employee** (*Age 56 - 80*): up to **$30,000**
	Spouse (*Age 18 - 55*): up to **$25,000**	**Spouse** (*Age 56 - 80*): up to **$10,000**
	Children (*Age 30 days - 23*): up to **$7,000**	
Premium Rate	Premiums remain level, then stop at Age 65	Premiums remain level for Life
Settlement Options *Available at claim time.*	• Death benefit paid in full to the beneficiary; • Annuitize the death benefit; • Or a combination of both.	• Death benefit paid in full to the beneficiary; • Annuitize the death benefit; • Or a combination of both.

AVAILABLE RIDERS

Terminal Illness Accelerated Benefit Rider *Upon proof of terminal illness, insured will receive 50% of the current benefit available prior to death, subject to provisions of the rider.*	*Issue Age 30 Days - 55* No additional charge for this rider	*Issue Age 30 days - 80* No additional charge for this rider
Waiver of Premium Disability Rider *Upon proof of the insured's total disability as defined by this rider, the company will waive any premiums due (on standard policy only).*	*Issue Age 15 - 55* No additional charge for this rider	*Issue Ages 15 - 55* No additional charge for this rider
Accidental Death Benefit Rider *This rider pays up to $32,000 for an Accidental Death, subject to policy provisions. This benefit pays in addition to other sums collected under the policy. Policy terminates at age 65.*	*Issue Age 30 days - 55* **$16,000 Face Amount** $1.00 bi-weekly **$32,000 Face Amount** $2.00 bi-weekly	*Issue Age 30 days - 55* **$16,000 Face Amount** $1.00 bi-weekly **$32,000 Face Amount** $2.00 bi-weekly
Children's Term to 25 Rider *Upon proof of the insured child's death, policy will pay beneficiary up to $10,000, subject to policy provisions*	*Issue Age 30 days - 23* **$10,000 Face Amount** $4.00 bi-weekly	*Issue Age 30 days - 23* **$10,000 Face Amount** $4.00 bi-weekly

* For those still actively employed subject to certain limitations. Not available to individuals who are HIV positive or terminally ill.
** Graded Benefit: initial policy benefit is 25%; second year – 50%; third year – 75%; fourth year and thereafter – 100%

ESD0663

Long-Term Disability Coverage

The long-term disability (LTD) plan pays benefits if you become disabled for an extended period of time. If you are a full-time employee and you work a minimum of 20 hours per week, you may purchase LTD insurance through CIGNA. This plan is a voluntary plan, meaning if you participate you are responsible for the entire cost of the premium.

Your Age	Cost Per Dollar of Bi-weekly Payroll
Less than 20	$0.00262
20-24	$0.00262
25-29	$0.00262
30-34	$0.00406
35-39	$0.00406
40-44	$0.00536
45-49	$0.00770
50-54	$0.01004
55-59	$0.01199
60-64	$0.01238
65 and older	$0.01238

A sample contribution calculation

Your salary = $32,000 at age 32

$32,000 divided by 26 pay periods = $1,231

$1,231 multiplied by $0.00406 (rate) = $5.00 per paycheck

Bi-weekly salary maximum is $3,846.

The LTD benefit provides you with income when you are unable to work for at least 90 days. You must be disabled as a result of a covered injury or sickness, and you must be under the appropriate care of a licensed, practicing physician who is qualified to treat your disability. Once you have been approved by CIGNA and disabled for 90 days of continuous disability, you will begin to receive disability benefits up to 60% of your eligible prior pay not to exceed $5,000 of benefits per month. (The minimum monthly benefit is $50.) The maximum amount may be reduced if you are receiving other sources of disability income from programs such as:

- Workers' compensation
- Social Security
- Another group disability or State disability plan
- A retirement plan, including PERA sponsored by your employer
- A dependent's coverage in which benefits are payable due to a covered person's disability
- Other government plans

If you are diagnosed with mental illness, drug or alcoholism benefits are limited to a 24-month lifetime maximum.

If you die while receiving benefits from the plan, a three-month sum will be paid to your beneficiary.

This plan contains a pre-existing limitation. This means that if you received medical treatment within three months before your coverage becomes effective, the plan will not pay benefits for a disability related to that condition. This limitation does not apply to a disability that begins after you are covered for at least 12 months after your coverage takes effect.

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A Business of Caring.

Definition of Disability

In order to receive benefits, you must be considered disabled under the plan, which generally means:

- **For the first 24 months of your disability,** you are not able to perform the duties of your own occupation and you are unable to earn more than 80% of your prior income.
- **After 24 months of disability,** you are not able to perform the duties of any occupation and you are unable to earn more than 60% of your prior income.

See the plan document for details, including limitations and exclusions.

Underwritten by Life Insurance Company of North America. A list of exclusions and limitations is included in the enrollment brochure. This information is a brief description of the important features of the plan. It is not a contract. In the event of a discrepancy between this summary and the group insurance policy, benefits will be paid according to the terms and conditions of the policy. Please refer to your Life Insurance Company of North America brochure for a complete description of benefits, limitations and exclusions.

Flexible Spending Accounts

You may choose to participate in one or both of the flexible spending accounts:

- Medical Care Reimbursement Account
- Dependent Care Reimbursement Account

These accounts are administered by BASIC, who holds your payroll deductions and makes reimbursements to you out of your account(s). You must complete the Flexible Benefit Plan Election/Change Form and the Direct Deposit Authorization Form (located on the back of the enrollment form) to participate.

The medical care reimbursement account lets you set aside tax-free-dollars for a wide range of health-related expenses that are not covered by the medical, dental or vision plans. You do not have to enroll in the medical, dental or vision plans to participate in this program.

The dependent care reimbursement account lets you set aside tax-free dollars for eligible day care expenses for your dependents.

For expenses to qualify:

- You and your spouse must be employed or actively seeking employment or attending school full time.
- Dependent care provider must claim payments as income.
- Dependent care expenses paid during a sick leave, holiday, or vacation are not eligible.
- Expenses must be for the care of a qualified person:
  - A child under 13 years old who is a dependent for income tax purposes. (If your child turns 13 during the plan year, expenses are no longer eligible for reimbursement.)
  - A spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day in your home (i.e. an invalid parent). The same rules that apply for child care apply to the care of other dependents, except that the dependent need not be under age 13.

How the Accounts Work

First, you must incur an eligible expense. Then, you submit a Reimbursement Form and receipts to BASIC. You will receive the reimbursement through direct deposit if you complete the Direct Deposit Authorization Form. Since you are reimbursing yourself with "tax-free" dollars, you have more buying power than if you paid for the same expenses with after-tax dollars.

When you enroll, you need to decide how much you would like to contribute to your accounts each year:

- **For the medical care account,** the plan minimum is $260 (or $10 per pay check) and the maximum is $5,000 per eligible employee per year. If you and your spouse are employed by the City each can contribute $5,000.
- **For the dependent care account,** the plan minimum is $260 (or $10 per pay check) and the maximum is $5,000 (married-filing jointly) or $2,500 (married-filing separately) each year.

You must carefully consider how much you would like to contribute. Because of the tax break, the IRS requires a "use it or lose it" feature for this benefit. That means if you have not incurred enough qualified expenses by the end of the plan year, it will be forfeited. The $4.25 fee per participant per month will be paid by the City.

You must enroll each year if you want to continue participating in the flexible spending account program.

BASIC WESTERN USA

Learn More

You can find more information at **http://eweb.cabq.gov/**

www.basiconline.com

The dependent care account is a pay-as-you-go account. You may only be reimbursed up to the amount you have contributed to the account.

You should check with a tax advisor to see what your savings might be if you participate in the flexible spending account program.

Note that you are unable to use certain tax credits if you use the FSA accounts.

Federal regulations do not permit expenses for domestic partners to qualify for the flexible spending accounts.

This is an example of how you can save tax dollars with an FSA.

	With FSA	Without FSA
Annual income	$40,000	$40,000
Estimated health care expense	$3,500	$0
Taxable income	$36,500	$40,000
Estimated federal tax	$5,475	$6,000
Estimated Social Security tax	$2,792	$3,060
Healthcare expenses	$0	$3,500
Net pay	$28,233	$27,440
Savings with FSA	$793	N/A

Eligible FSA medical expenses include:

- Ambulance service
- Birth control
- Co-pays and deductibles
- Crutches
- Eye glasses
- Nursing care
- Medically prescribed physical therapy
- Orthodontics[1]
- Over-the-counter medicines such as pain relievers, antacids, allergy medicines and cold medicines[2]
- Smoking cessation programs, nicotine patches, and nicotine gum
- Special Needs[3]

For a comprehensive list of eligible expenses, visit www.irs.gov and search for IRS Publication No. 502.

Eligible FSA dependent care expenses include:[4]

- The costs for dependent day care, at home or in a day care center
- Nursery school expenses

For more information, visit www.irs.gov and search for IRS Publication No. 503.

Debit Card Option

Participants in the Flex Medical and/or the Flex Dependent Care plan may elect to receive a debit card. This can be used like a credit card to purchase qualified items or services, such as office visit and prescription drug co-pays. This option is an alternative to paying out of pocket and being reimbursed by the plan. This includes being able to purchase over-the-counter medical items such as cold medicine. A form separate from the plan enrollment form is required to apply for the debit card for yourself, spouse and any qualified dependents over age 18.

BASIC WESTERN USA

Western USA, Inc.
B.A.S.I.C. FLEX

2526 E. Lee Street
Tucson, AZ 85716

During Open Enrollment:
800-473-0455

After July 1:
800-444-1922, Ext. 1

City Sponsored Benefit

FISCAL YEAR 2009

- City paid benefit
  - No employee cost to join
- Permitted to change contributions
  - Increase/decrease amounts*
  - Drop out of FSA*
- Medical Reimbursement Increase
  - Limit: Up to $5,000
- Dependent Care Expense
  - Limit: Up to $5,000

24/7 ACCESS TO ACCOUNT BALANCES

- IVR: Toll Free Number
- Internet Access

ADVANTAGES

- Save Payroll Taxes
  - 20% to 40% savings on:
    - Out-of-pocket medical, dental and vision
    - Day care expenses

QUICK, FAST TURNAROUND ON CLAIMS

- Direct deposit available
- Claims processed daily
- Designated Service Representative
- Debit card option

** If IRS approved status change occurs*

Examples of ***ineligible health care expenses*** include Retin-A, weight loss programs, health club dues, diaper service, long-term care expenses.

Examples of ***ineligible dependent care expenses*** include transportation expenses, convalescent or nursing home expenses and overnight camp expenses.

Parking and Transit Plan (Section 132 Plan)

Now you can also save money on your transit costs (up to 40%) by joining the parking and transit program administered by BASIC.

You can pay for your work-related parking and mass transit costs with tax-free dollars. Because the City pays the administration fee, there is no cost to participate in this program.

How Much You Can Allocate Tax-Free?

The 2008 fiscal year limit for mass transit is $110 per month and $215 per month for parking.

Any unused funds continue to roll over month-to-month, year-to-year as long as you are an active employee.

Enrolling

City-Owned Lots:

You must contact the Parking Division of the Municipal Development Department at 924-3950. By enrolling through them, your monthly salary reduction will automatically be applied to your payment due for parking.

Non-City Lots:

You must enroll online at www.basiconline.com Click on BASIC Parking. Click on submit expenses to complete the enrollment form.

To receive reimbursement for non-City lot parking, expenses must be submitted online at www.basiconline.com. You will receive your reimbursement by direct deposit only.

What Expenses Are Eligible

Your parking expenses on or near the premises of the City of Albuquerque or a location from which you commute to work by train, bus, van or carpool.

Parking/transit expenses resulting from travel to or from meetings, to visit other City departments, or other locations are ineligible for reimbursement.

[1]Reimbursement can only be made in accordance with the orthodontia contract, (e.g., monthly quarterly, etc). The orthodontia contract must be provided with each claim.

[2]These items must be purchased to alleviate or treat personal injury or sickness. Eligible items do not require a prescription. If the cash register receipt does not show the item description, a copy of the product packaging with price tag will be needed with the receipt.

[3]The service must be prescribed by a physician to treat a medical condition. Treatment cannot be for general health and/or well being.

[4]The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (i.e. an older child).

- If the services are provided by a day care facility, that facility must comply with state day care regulations.
- Services must be for the physical care of the dependent, not for education, meals, registration, etc.
- Overnight camps and lessons in lieu of day care are not eligible for reimbursement from a dependent care account.

Supplemental Retirement Plans

'Your 457 Deferred Compensation Program'

Deferred Compensation seeks to provide the **"Extra"** money you need for a more enjoyable and comfortable retirement lifestyle.

What is Deferred Compensation?

- Voluntary, IRS-approved retirement savings plan
- Pre-Tax and Tax Deferred (Income taxes are due in the year in which the money is withdrawn)
- Deducted from paycheck

Contact your Plan Representative for more information.
Your Benefits Department offers these Deferred Compensation Providers:

Your Benefits Department offers these Deferred Compensation Providers:

Representative:	**Steve Lopez**
Telephone:	(505) 842-8610
Toll Free:	(800) 669-7400
Email:	slopez@icmarc.org
Representative:	**Frank Morales**
Telephone:	(505) 892-2554
Email:	fmorales@icmarc.org
Representative:	**Dennis Dexel**
Telephone:	(505) 899-5011
Email:	ddexel@icmarc.org

ICMA RC

Serving the following entities:

City of Albuquerque
Bernalillo County
Town of Bernalillo
Sandoval County
SSCAFCA

AIG® **Retirement**

Representative:	**Jeremy Mitchell, CFP©**
Mobile:	(505) 263-4180
Toll Free:	(800) 892-5558 x87607
Email:	jeremy.mitchell@aigretirement.com

AIG Retirement

Serving the following entities:

City of Albuquerque
Bernalillo County
Sandoval County
SSCAFCA

Securities and investment advisory services are offered by AIG Retirement Advisors, Inc., member FIRNA, SPIC and an SEC-registered investment advisor.

Nationwide®
Retirement Solutions
a Nationwide® Financial company

Representative:	**Paul Lium**
Telephone:	(505) 989-4992
Toll Free Tel:	(866) 827-6639 ext 44419
Fax:	(505) 989-4991
Email:	liump@nationwide.com
Website:	www.newmexico457dc.com

NATIONWIDE

Serving the following entities:

City of Albuquerque

Start saving for retirement now rather than later…

For example: One employee began a deferred compensation account at age 30 and saved $2,000 per year for ten years ($20,000.) Averaging an 8% rate of return, at age 65 she had accumulated $198,422.

However, another employee did not begin a deferred compensation account until age 40, saving $2,000 ever year for 25 years ($50,000.) With the same 8% return, the total was $157,909 at age 65. Waiting to begin made a difference of over $40,000 in earnings and $30,000 in employee contributions.

Remember that investments don't grow at an even rate of return and may even lose value.

Contact a representative today to learn more!

Contacts and Resources

Employer

Office	Contact Name and Number
City of Albuquerque Insurance and Benefits Office 768-3758 City Hall 7th Floor, Room 702	Mark Saiz Human Resources Manager Insurance and Benefits 505-768-3758 (Fax) 505-768-3760
Santa Fe PERA Office	800-342-3422
Albuquerque PERA Office	505-883-4503
Santa Fe Retiree Health Care Office	800-233-2576
Albuquerque Retiree Health Care Office	505-222-6400

Insurance Companies

	Provider Group Number	Customer Service Web Site Addresses
Medical	Presbyterian GR1365	505-923-5678 or 1-800-356-2219 www.phs.org
	CIGNA 3327434	1-800-244-6224 www.cigna.com
Dental	Delta Dental 2517-0001	877-395-9420 505-855-7111 www.deltadentalnm.com
	United Concordia 844614	800-332-0366 www.ucci.com
Vision	Davis Vision ABQ001	800-999-5431 www.davisvision.com
Life and AD&D Insurance	CIGNA (Basic) FLX980032 (Voluntary) FLX980018	800-238-2125, ext. 3406 www.cigna.com
	Globe Life	866-298-9115 www.buy-globe-life.com
Disability Coverage	CIGNA FLX980018-001 VDT960021-001	800-781-2006, ext. 6256 www.cigna.com
Supplemental Retirement Plans	AIG Retirement	505-263-4180 (Jeremy Mitchell, CFP©) www.aigretirement.com
	ICMA	800-669-7400 Customer Service Dept. 505-842-8610 (Steve Lopez) 505-892-2554 (Frank Morales) 505-899-5011 (Dennis Dexel) www.icmarc.org
	Nationwide	866-827-6639, ext. 44419 Toll-free Customer Service Paul Lium 505-989-4992 Santa Fe Office 505-989-4991 Fax www.newmexico457dc.com
Flexible Spending Accounts	BASIC Western 503	800-444-1922, ext. 1 www.basiconline.com
Parking/Transit Plan	BASIC Western	800-444-1922, ext. 220 www.basiconline.com

Human Resources Department
Patricia D. Miller, Director
768-3700

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